TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HILLCREST BAPTIST MEDICAL CENTER

Respondent Name
SENTRY CASUALTY COMPANY

MFDR Tracking Number
M4-14-2332-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted these bills within Timely Filing via fax to the WC Carrier, Travelers. We received a 'rejection letter' with our bills returned marked 'no claim on file' due to the employer did not submit a 'first report of injury' as a reason for our bills being rejected/returned."

Amount in Dispute: $4,981.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2014	Emergency Room Visit	$4,981.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.

Issues

1. Did the health care provider submit the medical bill to the correct insurance carrier?
2. Is the dispute eligible for medical fee dispute resolution?

Findings

1. Review of Division records finds that the insurance carrier responsible for payment of the disputed claim is Sentry Casualty Company. The health care provider submitted the medical bill(s) to Travelers. Per 28 Texas Administrative Code §133.20(a) "(a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section." No documentation was found to support that the provider submitted the medical bill(s) to the correct insurance carrier (Sentry Casualty Company) for consideration of the claim. The requestor has therefore failed to meet the requirements of §133.20.
2. The health care provider has not submitted the medical bill to the insurance carrier for consideration of payment for the claim as required by 28 Texas Administrative Code §133.20. Accordingly, the Division finds that the dispute is not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division has found that the dispute is not eligible for medical fee dispute resolution. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	June 17, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.